

Exhibit 1: Model Medicare-Medicaid Individual Enrollment Request Form

Referenced in §§ 10.3, 30.1.1, 30.1.2, 30.2, 30.2.1

Keep a copy of this form for your records

Commonwealth Coordinated Care Enrollment Application Form

To join a Commonwealth Coordinated Care plan, you must have **Medicare Part A**, **Medicare Part B**, and **Medicaid**. You can also call the enrollment broker at 1-855-889-5243 (TTY: 1-800-817-6608), between 8:30 am to 6:00 pm Monday-Friday to join the Commonwealth Coordinated Care plan. The call is free. Translation services are available.

Choose a health plan:

- ☐ Healthkeepers, Inc.
☐ Humana Health Plan

☐ Virginia Premier Health Plan,

Tell us about yourself:

Name: (first, middle, last)			
Date of birth: (<u> </u> / <u> </u> / <u> </u> M M D D Y Y Y Y)		Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Phone number: (<u> </u>) <u> </u> - <u> </u>	Another phone number: (<u> </u>) <u> </u> - <u> </u>	Email Address:	
Address where you live: (P.O. Boxes are not acceptable for address of residence)			
City:	State:	ZIP code:	County:
Address where you get mail (if different from where you live):			
City:	State:	ZIP code:	County (Optional):
Emergency contact name:		Emergency contact phone: (<u> </u>) <u> </u> - <u> </u>	



If you are not a native English speaker, you can call 1-855-889-5243 to get the form in a different language. TTY users should call 1-800-817-6608.

Tell us where you usually get health services:

Name of your primary care provider, clinic or, health center:	Phone number: (____) ____ - _____
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Tell us about your Medicare & Virginia Medicaid coverage:

Fill in your Medicare and Virginia Medicaid information below. You can find this information on your red, white, and blue Medicare card, or a letter from Social Security or the Railroad Retirement Board. Also, please put your 12 digit Virginia Medicaid ID number as it appears on the front of your card.

 SAMPLE ONLY Name: _____ Medicare Claim Number _____ Sex _____ ____ - ____ - ____ Is Entitled To _____ Effective Date _____ HOSPITAL (Part A) _____ MEDICAL (Part B) _____	 010900 000000000000 SAMPLE MEDICAID DOB: 00/00/0000 M CARD# 000000
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Medicare Claim Number: _____ Medicaid ID Number: _____

Other personal information:

Do you have End-Stage Renal Disease (ESRD)? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" and you've had a successful kidney transplant and/or no longer need regular dialysis, please attach a note from your doctor.
Do you live in a long-term care facility? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, fill in the information below:

Name of the facility:		Phone number: (____) ____ - _____
Do you work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your spouse work? <input type="checkbox"/> Yes <input type="checkbox"/> No

Your health coverage including your prescription drug coverage:

Some people have other health insurance or drug coverage through private insurance, TRICARE, Employers, Unions, Veterans Affairs, or the State Pharmaceutical Assistance Programs.

Do you have other health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, fill in the information below:</i>	
Name of your plan <i>(and employer, if applicable)</i> :	Group number:
	ID number:
Name of your plan <i>(and employer, if applicable)</i> :	Group number:
	ID number:
Name of your plan <i>(and employer, if applicable)</i> :	Group number:
	ID number:
Name of your plan <i>(and employer, if applicable)</i> :	Group number:
	ID number:
Name of your plan <i>(and employer, if applicable)</i> :	Group number:
	ID number:
If you have comprehensive health coverage from an employer or union, you are not eligible for enrollment into the Commonwealth Coordinated Care Program at this time.	

Please read and sign below.

When you sign this form, it means that you understand:

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| <ul style="list-style-type: none">• Commonwealth Coordinated Care (CCC) has a contract with the federal government and with Virginia.• The health services you get with your new plan may be different than the services you had before.• I must keep Medicare Part A, Part B and Virginia Medicaid.• I can be in only one Medicare plan at a time.• By joining CCC plan, I will end my enrollment in another Medicare health or prescription drug plan.• I must tell Medicare and Virginia Medicaid about any prescription drug coverage that I have or may get in the future.• If I move, I need to tell the local Department of Social Services and the enrollment broker at 1-855-889-5243 (TTY: 1-800-817-6608), between 8:30am to 6:00pm Monday-Friday.• As a member of CCC plan, I have the right to appeal if I don't agree with CCC plan's decisions about payment or services.• The CCC plan doesn't usually cover people while they're out of the country.• On the date CCC plan coverage begins, I must get my health care from CCC plan doctors, except for emergency or urgently needed care, out-of-area dialysis or if I get CCC plan or State's approval to see other providers in some circumstances.• If I need to see a doctor or other provider who is not in CCC plan, I may need prior authorization or I may have to pay out-of-pocket for the services I get. | <ul style="list-style-type: none">• By joining CCC plan, I know that CCC plan may share my information with Medicare and Virginia Medicaid and other plans as necessary for treatment, payment, and health care operations.• I understand that prescription drugs are covered, but not always the same ones I'm already taking. I understand that I'll have access to my current drugs for at least 90 days, until I can switch to a different drug, and that I will have access to my current doctors for 180 days once I join CCC plan. I further understand that CCC plan has providers and pharmacies I must use to get health care services, except for non-routine, emergency situations.• I know that CCC plan may share my information including my prescription drug information with Medicare and Virginia Medicaid. They may release it for research and other purposes, as allowed by Federal statutes and regulations.• The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I'll be disenrolled from the CCC plan.• My signature (or my authorized representative's signature) on this form means that I've read and understood this form. If an authorized representative signs, the person's signature means that he or she is authorized under State law to complete this enrollment, and documentation of this authority is available upon request from Medicare and/or Virginia Medicaid program. |
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Your signature:	Date:
<p>If you are the authorized representative, you must provide the following information, sign, and date below:</p> <p>Name: _____ Signature: _____ (Please Print)</p> <p>Address: _____</p> <p>Phone Number: (_____) _____ - _____</p> <p>Relationship to Enrollee: _____</p> <p>Today's Date: _____</p>	

For more information, visit www.virginiaccc.com. **If you have questions,** call the enrollment broker at 1-855-889-5243 Monday-Friday 8:30am - 6:00pm. TTY users should call 1-800-817-6608. The call is free. This information is available for free in other languages and formats like Braille or audio CD. *[The preceding sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.]*